# Exhibit B

**Acknowledgement of Telecommuting Conditions and Responsibilities**

1. I Louis DeCosmo, spoke with my supervisor and understand that this telecommuting arrangement is conditional and may be modified or terminated by management at any time, with or without prior notice to me. I also understand that during the telecommuting arrangement I may be required to attend meetings and/or work at the Hospital at any time at management's discretion.

2. I understand that telecommuting is a privilege, not a universal benefit or employee right. I also understand that telecommuting is voluntary and that I may stop at any time.

3. I understand that I am approved to telecommute, ***please check one***:

☒ Occasionally upon approval of my manager – no regular telecommuting schedule

**OR**

☐ On a regular telework schedule and I am scheduled to telecommute on the following days, ***please check all that apply***:

__Monday __ Tuesday __ Wednesday __ Thursday
__Friday __ Saturday __ Sunday

My core hours on telecommuting days when I will be available to my supervisors and co-workers are: _____am/pm to _____am/pm

4. I understand that the Hospital's electronic communications systems and equipment, including but not limited to email, belong to the Hospital and that I should have no expectation of privacy in any data, information or communication, including email or social media posts that is received from, accessed through, stored or recorded on, transmitted to or printed from Hospital electronic systems or equipment, even for personal use. I understand that the Hospital has the right to monitor and access all NYP equipment and systems, with or without notice to me.

5. I understand that except for very limited incidental personal use that does not interfere with my work performance or any applicable Hospital policy or law, I am only permitted to use Hospital information or electronic systems or equipment for valid Hospital business.

6. I understand that I must maintain a secure work area and protect the confidentiality of all Hospital information, including all business sensitive information and Protected Health Information. I understand that my supervisor or his/her designee may inspect my work area to confirm that it is adequately secure.

7. I understand that I must comply with all Hospital privacy and security regulations and policies protecting the confidentiality of business sensitive information and Protected Health Information, including, but not limited to, strong password protection and encryption, including on my personal devices (including laptops, desktops, smart phones, tablets, USB, CD, DVD, other storage) if used for telecommuting purposes. When I have finished using any confidential information necessary for my job I will promptly shred it or securely return it to work, at my supervisor's direction.

8. I understand that I must notify my supervisor and the Hospital's Privacy Officer immediately if any NYP confidential information has or may have been, lost or misappropriated.

9. I understand that I must check in on a daily basis, or as otherwise required by my supervisor.

Please check the **ONE** that applies:

☐ I am eligible for overtime and I will clock in at the start of my workday and clock out at the end of my workday using the KRONOS desktop timekeeping system so that there is a record of all my time worked including all overtime. I understand that I will be paid for all time worked including all overtime. I also understand that my failure to properly clock in and clock out each and every work day and my failure to seek pre-approval from my supervisor before working overtime may result in my receiving corrective action.

**OR**

☒ I am an exempt employee and am not eligible for overtime. I have set up a system approved by my supervisor to accurately report each day I work remotely.

10. I understand that I should only be doing Hospital work during my telecommuting work hours and that unauthorized (non-Hospital) work during my scheduled work time is prohibited. I understand that I am not allowed to work for another employer or run my own business during work time. I also understand that this telecommuting arrangement cannot be used as a substitute for dependent or child care.

11. I understand that the same Hospital policies that apply to employees working onsite, including, but not limited to, attendance, leave of absence, incident reporting, code of conduct and corrective action, apply to me as well.

12. I understand that I should report to my supervisor all job related incidents or injuries I sustain during work hours. Job related injuries occurring during my defined work hours and approved work area will be covered by Workers Compensation. Workers Compensation will not apply to non-job related injuries or injuries to third parties or my family.

13. I also have been advised that this conditional telecommuting arrangement which can be ended at management's discretion at any time, with or without prior notice to me, and does not change the at will status of my employment at the Hospital.

**I have read, discussed with my supervisor, and understand, my responsibilities and the conditions upon which I have been conditionally approved to telecommute.**

| Louis J. DeCosmo | Christopher Lowe |
|---|---|
| **Employee's Name** | **Supervisor's Name** |
| Louis J. DeCosmo | Christopher Lowe |
| **Employee's Signature** | **Supervisor's Signature** |
| 02/15/2017 | 02/15/17 |
| **Date** | **Date** |

***To be completed by HR Business Partner:***

Please verify the information below for the employee requesting a Telecommuting Arrangement:

| 104678 | decosmo@hpfb.org | |
|---|---|---|
| **ID #** | **USER NAME (e.g. "abc9000")** | |
| WC | Exempt | Director IT |
| **CAMPUS** | **FSLA STATUS (exempt or nonexempt)** | **TITLE** |

**Did the department present to you their plan for monitoring the employee's productivity?**

☑ YES ☐ NO

| Mario King | 3/30/17 |
|---|---|
| **HRBP NAME (please print)** | **DATE** |